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ABSTRACTS OF PAPERS PRESENTED AT SECTION MEETINGS

Section of Pediatrics, December 9, 1926

DIETARY OF THE CHILDREN'S SERVICE CITY HOSPITAL

WALTER LESTER CARR

In the arrangement of a dietary for a children's hospital, consideration must be given to food value, palatability and last, but not least in a city institution, to cost per patient. The first of these may be easy, especially for babies and young children where milk, cereals and vegetables will be all the articles required for proper nutrition. For older children, however, there will be difficulty in arranging a dietary that will be palatable, especially if a child's digestion has been spoiled by irregularity in meals and by food of an unsuitable character. Such children will be hard to feed until they become accustomed to a hospital table. It was with these facts in mind that the dietary at the City Hospital was planned, for food value, palatability and cost. The diet sheet in use on the pediatric service was drawn up after a careful survey, and in its preparation I was assisted by Dr. George J. Plehn, house-physician on the pediatric division, now radiologist to the hospital. The feeding ward of twenty-five beds has the advantage of a supply of Walker Gordon milk, certified by the Milk Commission of the Medical Society of the County of New York. The cost of such certified milk adds to the general expense of the

diet and increases the per capita rate for the service, but as fresh certified milk is the basis for infant feeding, its value is not to be calculated too closely, especially as it does away with many items of hospital expense and lessens the need for nursing, as a baby well nourished and comfortable does not require so much attention as an enfeebled malnourished one.

The articles selected for older children, of an average age of 5.2 years, were chosen for food value, palatability and availability; the last being important, as in the Department of Public Welfare food is bought by contract and its distribution to city institutions must depend upon market conditions. Although all food named in the dietary was not chosen entirely for its caloric value, attention was paid to it as essential to a proper understanding of nutrition.

The milk included in the diet of older children is, unless by special order calling for certified milk, the regular pasteurized supply obtainable in New York City. This milk is required by the Department of Health to be of a 3 per cent. butter fat—1 per cent. less than certified milk. When reading the sample table of diet, I wish it understood that the *daily allowance* and the *daily amount consumed* are not the same, as the daily allowance includes articles in excess of the amount consumed, because the supplies for the wards must be a maximum and not a minimum, lest an extra hospital census should reduce the food per capita below what is needed for each child's nutrition. For example: each child is allowed 1½ oz. of butter per day, but not all is consumed. The sugar allowance is 2½ oz. a day, while the amount consumed is only an average of 1 oz. plus, a day, so that sugar for special diet is available. Milk is in the same category, as there is a daily allowance of one quart for each child, but the milk calculated is used for custards and selected diet. Meat in chop has to be computed by weight, which includes bone, thus there is a loss in caloric intake that can only be averaged and should not be included in the tables. Cereals are used every day, but the one most liked is oatmeal. Prunes, contrary to popular opinion, are liked by the children. Apples and other fruit are not so much in demand as oranges.

Sample Breakfast		*Calories*[1]	*Cost*	
Bread	2 oz.	160	.0046	cents
Butter	½ oz.	75	.0085	"
Oatmeal	¾ cup, cooked	100	.0019	"
Milk	12 oz.	252	.0420	"
Sugar	½ oz.	60	.0017	"
Orange	1	56	.0346	"
		703	.0933	
Sample Dinner				
Bread	2 oz.	160	.0046	cents
Butter	½ oz.	75	.0085	"
Milk	8 oz.	168	.0280	"
Potato	8 oz.	260	.0136	"
Tomato	3 oz.	30	.0123	"
Egg	1	80	.0288	"
Fish	8 oz.	150	.0270	"
		923	.1228	With Fish
or				
Chop	8 oz. (less wgt. of bone, 4 oz.)	425	.1200	
		1,198	.2158	With Chop
Sample Supper				
Milk	12 oz.	252	.0420	cents
Bread	2 oz.	160	.0046	"
Butter	½ oz.	75	.0085	"
Oatmeal	1 oz.	100	.0019	"
Sugar	½ oz.	60	.0017	"
Prunes	1 oz.	80	.0051	"
Crackers	1 oz.	100	.0075	"
		827	.0713	
Daily amounts including egg *and* chop in sample dinner—Calories		2,828	Cost[2]	.3804
	Less waste	500		
		2,328		

[1] Calories estimated by Dr. I. J. Levy, in charge of the metabolic ward at the City Hospital, based in part on Locke's tables.

[2] Cost per capita U. S. Soldier, 36 cents. Cost per capita U. S. Cadet at West Point, 80 cents.

Daily estimated allowance		*Calories*	*Cost*
1 Orange or Orange Juice	1	56	.0346 cents
Oatmeal	¾ cup, cooked	100	.0019 "
Bread	12 oz.	960	.0276 "
Sugar	2½ oz.	300	.0087 "
Milk	1 quart	672	.1100 "
Butter	1½ oz.	340	.0384 "
Lamb Chop	8 oz.	850	.1200 "
or			
Fish	8 oz.	300	.0270 "
Potato	8 oz.	260	.0136 "
Fresh Spinach	8 oz., as purchased	44	.0600 "
or			
Tomatoes	3 oz.	30	.0123 "
Egg	1	80	.0288 "
Prunes, dry	2 oz., as purchased	160	.0102 "
Crackers	1 oz.	100	.0075 "
Custard	4 oz.	174	.0245 "
	Milk, 4 oz. Sugar, ½ oz. Egg, ⅛ oz.		
Total calories using chop and spinach		4,096	.4858 cents
Total calories using fish and tomatoes		3,532	.3451 "

The nurses in the diet kitchen consider a fair deduction is 500 calories for each child; part of this is taken by older children and some no doubt is wasted.

Langworthy, U. S. Department of Agriculture, calculates that a man without work requires 2,450 calories; with light work 2,700 calories.

Section of Surgery, February 4, 1927

TREATMENT OF ACUTE SUPPURATIVE PLEURISY IN CHILDREN

JOHN V. BOHRER

Suppurative Pleurisy in children presents a difficult problem. It is essentially a secondary disease, a child's vitality having already been depleted by primary pneumonia. Complications such as acute otitis media or recurrence of pneumonia, especially in cold windy months, are very common, and this markedly increases the severity of the disease and in infants (those under two years of age) this disease is particularly severe. The older text books

of pediatrics state that the mortality in suppurative pleurisy in infants under one year of age is one hundred per cent. Fortunately this is not the case at present. In our series the youngest patient operated on for suppurative pleurisy was three weeks old. This patient recovered as did many others in the infant group.

The plan of treatment should fulfil the following requirements, and in so far as it yields good results must be accepted as satisfactory:

1. Proper treatment of the primary disease with early recognition of the suppurative pleurisy.
2. Low mortality.
3. Minimum anatomical and physiological deformity.
4. Prevention of complications.
5. Early restoration to health.

In the formative stage, if there is distress, repeat aspiration as often as necessary. In a few instances, in streptococcus cases, where the re-accumulation of pus is very rapid, the air-tight syphon drainage or suction method is used, but this is not entirely satisfactory; repeated aspiration is the better plan.

When the fluid is frank pus, and, as is often the case, the temperature from the pneumonia has abated, open drainage is instituted.

Intercostal drainage with the so-called "flapper tube" is the method used. A "flapper tube" is made by fitting a glove finger (one that has been softened by repeated sterilization) on the distal end of a fenestrated rubber tube as a projection, the tube having been cut with a sixty-degree bevel, forming a valve that readily allows fluid and air to escape with expiration, but which closes with inspiration. This is an aid in lung expansion, as it tends to restore the negative intra-pleural pressure, and is of use in irrigating at the time of dressing, as it forms a funnel through which irrigating fluid is passed into the chest cavity.

The operative procedure in a suppurative pleurisy is always done with local anesthesia. The patient, if not too sick, is allowed to sit up; cooperation is more likely to be had in this position.

A small incision is made in the seventh intercostal space near the mid-axillary line. Naturally the site of the incision varies

with the location of the pus. A "flapper tube" is introduced and the pus allowed to run out. The tube is held in place by one silkworm stitch. At no time have there been any disturbing symptoms caused by completely evacuating the cavity at operation. Irrigation is started in the next few days, the exact time depending on the condition of the patient and the amount and character of the drainage. Usually on the fourth day the cavity is irrigated, the patient reclining with wound uppermost. Saline is introduced through the "flapper tube," the measured amount determining the size of the cavity. If no coughing is produced, Dakin's solution is then used cautiously. If there is no "gassing" the cavity is now daily cleansed by thorough irrigation with Dakin's solution. This daily irrigation is not an attempt to sterilize the cavity, but is sufficient to keep thin and to deodorize the discharge.

When judged by temperature, appetite, type of discharge and general condition it is found that the patient has not materially improved at the end of eight or ten days, and there is no acute otitis media or recurrence of pneumonic process, we conclude that we are dealing with a complicated form of suppurative pleurisy, such as multiple loculi or a markedly thickened pleura preventing complete drainage, and exploratory thoracotomy is done.

Under light ether or gas anesthesia, an intercostal incision long enough to give proper exposure is made and rib spreaders introduced. If more exposure is required, a rib may be cut at one or both ends and telescoped, giving the desired extra exposure. This gives the advantage of seeing and under visual guidance dividing vicious adhesions, doing a partial decortication or any other procedure necessary, thus converting multiple loculi into a single cavity, or placing drainage where it is needed. This may appear radical surgery, but properly done it produces little shock and reduces mortality, shortens convalescence and causes no deformity.

The order of treatment in suppurative pleurisy is, first, adequate drainage; second, skilful nursing and high caloric diet; third, blood transfusion.

Only whole blood, by the Lindemann method, is given. With whole blood, accurately matched and given in proper amounts, reactions are seldom seen.

It is very difficult to make a classification of suppurative pleurisy cases, but for clinical purposes they may be divided into three groups:

a. Cases having good prognosis.

b. Cases having poor prognosis.

c. A middle group whose prognosis is largely dependent upon the kind of treatment received.

a. Good prognosis.

In this clinical grouping about forty per cent. of the patients come under the heading of good prognosis. By this is meant where the patient has inherited a healthy constitution, has been surrounded by fair conditions during health, where the primary disease was promptly and properly diagnosed and treated, and which developed encapsulated suppurative pleurisy, which in turn was promptly diagnosed and received proper care during the formative period of the disease. Such patients will recover if they are given adequate drainage by any of the methods advocated. The period of invalidism will be minimum. The type of organism is a minor matter. Recovery statistics in this group are very gratifying.

b. Poor prognosis.

In this group our series at Bellevue Hospital shows about twenty-five per cent. Through the Social Service Department we have found the living conditions included unhealthy parents, dirty, unsanitary homes, under-feeding and exposure. Rickets is almost universal. Add to this background a virulent infection, the primary disease improperly diagnosed, a starvation diet, and the child sent to the hospital only when in extreme condition. Such cases, with an encapsulated suppurative pleurisy, will often do surprisingly well if given adequate drainage and plenty of food. But in a patient with a virulent infection with complicated pleural involvement, or one who has already developed complications such as acute otitis media, or pneumonia of the opposite lung, the prognosis is universally bad regardless of the type of operative procedure.

c. Middle group where prognosis is largely dependent upon surgical procedure.

The remaining thirty-five per cent. fall into this group. In this class, where the background has been only fair, the treatment of

the primary disease good, but the infection virulent, the surgical treatment largely determines the ultimate outcome.

One hundred and fifty-four children's cases are here reported covering a five-year period from 1919 to 1924, inclusive. These children, ranging from infancy to twelve years of age, were admitted to Bellevue Hospital on Children's Surgical Service. These cases were divided into age groups for a statistical study. The first or infant group includes all children under two years of age; the second from two to six years, and the third from six to twelve years. The mortality of the first or infant group, forty-eight cases, is 35.4 per cent. For the second group, seventy-three cases, it is 10.9 per cent. For the third group, thirty-three cases, it is 3.3 per cent. The mortality for the entire series of a hundred and fifty-four cases is 16.8 per cent.

Section of Surgery, February 4, 1927

THE CONTROL OF POST-OPERATIVE HEMORRHAGE FOLLOWING NEPHRECTOMY FOR REMOVAL OF RENAL CALCULI

DOUGAL BISSELL

Ureterotomy for the removal of renal calculi has certain advantages, but should the ureteral incision fail to heal, one is driven to the necessity of removing the kidney.

Ureteropyelolithotomy was resorted to by the author from 1901 to 1916 in cases of renal calculi. In the latter year there came under his care a patient with a stone in the renal pelvis of considerable size. This stone was removed through an opening made in the upper ureter, but its delivery caused an irregular extension of the incision which was difficult to repair, and it became infected, with a resulting persistent fistula. Nephrectomy was finally necessitated. This unfortunate outcome directed the author's attention to the development of a nephrectomy technique for the removal of renal calculi with less liability to urinary fistula, and provision for the control of renal hemorrhage. The fea-

ture of the technique pertained chiefly to the closure of the renal incision and the removable sutures encircling the kidney, which are utilized, should necessity demand it, to stop post-operative hemorrhage.

When the kidney is delivered and the ureter freed from its cellular tissue and from the renal vessels, these vessels are compressed directly by a ring forceps covered with rubber. A median longitudinal incision is now made through the kidney and the calculi removed. The kidney incision is closed with a cambric needle large enough to accommodate No. 0 chromic catgut, the suture is doubled but its free ends are not tied. The small canal made by the needle is completely filled by the double suture. The needle is passed through the kidney substance on a plane with the cut edges of the pelvic incision and repassed on the same plane in the opposite direction so as to form a loop. The securing of this suture may be made in one or both of the following ways: First, the needle end of the double suture, after its final emergence, is passed through the double loop on the opposite surface and tied over the convex border to the free ends. Second, the double suture is severed from the needle and one of the severed sutures tied as a mattress suture while its companion single suture is dealt with in a similar manner, as are the double sutures in the first method. Two B and B silk sutures are now passed completely around the kidney, one just above the upper and the other just below the lower limit of the hilum. To prevent these sutures from losing their positions they are made to penetrate superficially the anterior and posterior surfaces of the kidney and deep enough only to secure an anchorage in the fibrous capsule. After releasing the hemostatic clamp and returning the kidney to its bed, the free ends of the B and B sutures are passed through all of the tissues on one side and the other of the lumbar incision and each tied in a bowknot over a bolster of iodoform gauze. These sutures, when tightened as necessity indicates, will ensure hemostasis and anchorage of the kidney to the abdominal wall.

The author reports a case which had been operated upon by another surgeon in 1913 for the removal of three calculi from the left kidney. Part of the technique then used was the passing of a rubber drainage tube through the kidney wound into the renal pelvis for direct drainage.

Operation

A left lumbar incision was made and great difficulty was encountered in freeing the kidney from the abdominal wall, and an extensive area of kidney surface was severely traumatized. After freeing the ureter and renal vessels from each other and their encircling cellular structure, the vessels were grasped by a rubber-covered ring forceps and the kidney incised longitudinally. The stone was then extracted from the pelvis. A cambric needle large enough to accommodate No. 0 plain catgut and threaded with this as a double suture, ends not tied, was made to penetrate the kidney substance on a plane parallel with the cut edges of the kidney pelvis; the needle was then re-entered at a point less than 1–2 cm. from its exit and made to penetrate the kidney again on the same plane and emerge at a point at about 1 cm. from its original entrance. Four of these sutures were passed about 1 cm. apart, the needle end of each individual set of sutures was passed through the double loops on the opposite surface and tied to the free ends over the convex border. Two removable encircling sutures of B and B silk were passed about the kidney, one above and one below the limits of the hilum as previously described.

Post-Operative History

During the first twenty-four hours a small amount of blood was found in the urine. No recurrence of bleeding until the fifth day, when bleeding continued for four days. The lumbar wound was dressed on the seventh day. No bleeding discovered. On the eighth and ninth days a considerable amount was noted, also a considerable amount in the urine.

Calcium chloride, 15 grains, was then given internally, also calcium lactate, grs. 5, t. i. d. by mouth. The bleeding was checked for eighteen hours, then recurred and continued for two days in spite of the continued use of both calcium chloride and lactate salts.

On the thirteenth day the small, thin rubber drain was removed and the lower encircling B and B silk suture sustaining the kidney was untied and retied tightly over a fresh bolster of gauze. Bleeding at once ceased and did not recur.

It would appear that the early bleeding into the kidney pelvis was the result of the yielding of the plain catgut used to ap-

proximate the cut surface of the kidney, and therefore chromic catgut of the same size should be substituted for it. Bleeding from the lumbar region did not occur until the eighth day, which suggests that its source was the traumatized kidney tissue of the lower pole. As calcium salts were given a fair trial, but failed to check hemorrhage permanently, and as the steadily-increasing hemorrhage was immediately and permanently checked both internally and externally by tightening the lower B and B suture encircling the lower pole, the value of the removable and encircling sutures under these circumstances would seem demonstrated.

Section of Neurology and Psychiatry, February 8, 1927

TUMOR OF THE MEDULLA

GEORGE H. HYSLOP

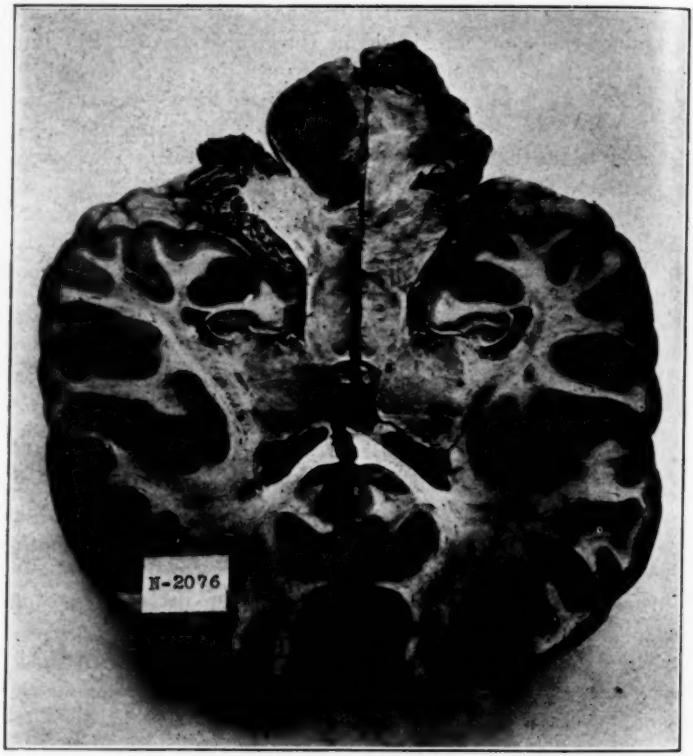
The patient was a boy of six whose past history was of no importance except possibly in that he had measles two months before the appearance of tumor symptoms.

In June, 1926, the parents noticed a gradually-increasing left internal strabismus. Because the boy seemed normal otherwise nothing was done about this. About the 10th of August thickness of speech and awkwardness in walking began. About the 20th of August difficulty in swallowing appeared, and a few days later there was clumsiness in the use of the right hand. During this time general weakness increased, and there seemed to be considerable loss of weight. Sleep was normal, there was no fever and the child suffered neither from headache nor vomiting.

About the last of August pain in the neck and back of the head developed and was troublesome whenever the child changed from the erect to the recumbent position.

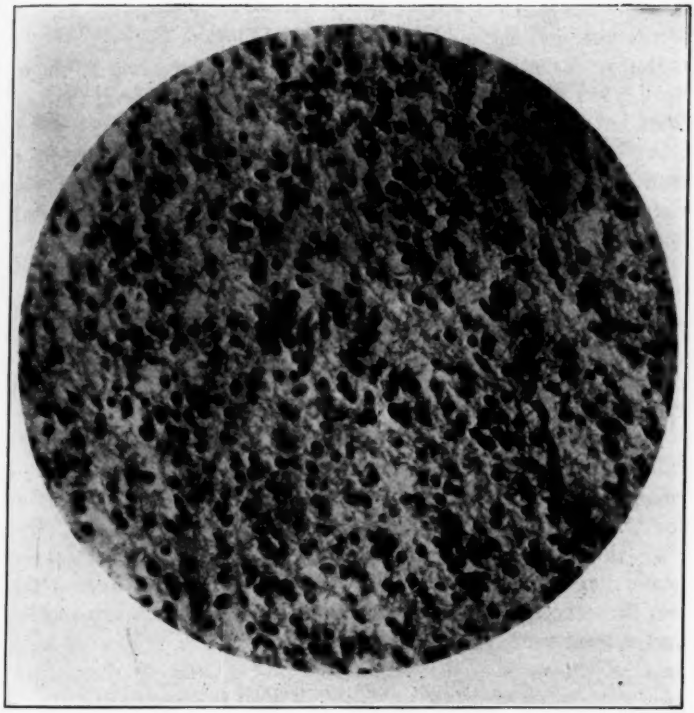
The child was examined on August 31st at the Post-Graduate Hospital. Skull X-ray was negative. Spinal fluid was normal and the eye grounds showed no evidence of intracranial pressure.

I saw the patient for the first time on September 3rd. The neck was held slightly flexed, and change of position seemed to be uncomfortable. The boy could neither stand nor sit without aid. Efforts to walk showed a marked cerebellar ataxia.



Cranial nerves showed the following abnormalities:

1. Venous engorgement of both retinae, blurring of the right disc and moderate edema of the left disc. The pupils were large and reacted normally.
2. Nystagmus, which was fine and rapid to the right, coarse and slow to the left.
3. Left external rectus paralysis.
4. Paralysis of the soft palate on both sides.
5. Speech almost impossible and voice almost a whisper.
6. Distinct weakness of the trapezius and sternocleidomastoid muscles.



7. Tongue atrophic on both sides. It could not be protruded.

There was hypotonia of all extremities, more marked on the right.

Non-equilibratory tests were performed poorly, especially on the right.

There was hypoesthesia to all forms of sensation on the right.

The arm reflexes were diminished. Knee and ankle jerks were absent.

There was bilateral Babinski and ankle clonus, and positive confirmatory signs. (Chaddock, Oppenheim.)

A diagnosis of tumor in the posterior fossa was made. It was located as probably in the vermis and overlying the fourth ven-

tricle, with indirect effects upon the right hemisphere of the cerebellum and the medulla.

Before operation hypertonic solutions of magnesium sulphate were given by rectum. This procedure lessened pressure symptoms.

At operation, performed by Dr. Elsberg on September 7, a marked medullary pressure cone was observed. No tumor was visible. The child died of respiratory failure a few hours after operation.

Necropsy showed a large soft mass lying on the left antero-lateral aspect of the pons and extending downward and backward toward the medulla from within which it seemed to arise.

On section is was shown that the tumor practically (filled) replaced and dilated the normal limits of the medulla, and had grown outward, upward and forward.

Dr. Penfield has done the histological and photographic work.

Primary tumors of the medulla are rare. They probably represent not more than 1 per cent. of all tumors of the intracranial cavity.

In this case the symptomatology may be attributed to the hemorrhage within the tumor. The clinical course during the last three weeks of life was too rapid to be explained adequately by the growth of tumor tissue itself.

Macroscopical Report

Leptomeninges: They are normal in appearance. Pial veins, no congestion. It is difficult to make out what has happened to the basilar artery. It may perhaps have passed through the tumor.

Brain: It seems to be normal in consistency. The convolutional pattern is not altered. There is some flattening of the convolutions. The ventricles are not, however, increased in size. The aqueduct of Sylvius is not occluded. The fourth ventricle is at least as large as normal in its antero-posterior diameter although the lateral recesses are obliterated. The ependyma and choroid plexus appears normal. In the body of the medulla oblongata a tumor is seen which on cross section is of a somewhat gelatinous consistency. It seems to have arisen in the substance of the medulla and has pushed this structure out in all directions but

mostly backwards. It is about 3.5 cms. in diameter. The neoplasm projects outward through the pia on either side of the midline, making a sort of cauliflower excrescence. This excrescence is larger on the left-hand side than on the right, being about a centimeter in depth here and somewhat less on the right. For some curious reason this excrescence does not pass across the midline but reappears on the other side. There seems to be no gross invasion of the cerebellum nor any extension upward into the pons. In the right side of the medulla there is a blood clot several centimeters in diameter, showing that there has been a hemorrhage into the tumor in this portion sometime before death. The tumor therefore has arisen within the medulla itself; it is not covered with a capsule, although the line of demarcation between it and the medulla is quite easily seen. It has not shut off the aqueduct of Sylvius, and to judge from the appearance of the brain did not cause an increase of intracranial pressure during any length of time. The pressure from expansion due to the tumor would have been directly upon the medulla involving to a very limited extent the pons.

Microscopical Report

The neoplasm is made up of cells whose nuclei vary a good deal in shape. For the most part the chromatin network is moderately dense and a few chromatin granules are to be seen. Where the tumor is rapidly growing there is little cytoplasm. Fibers are stained with phosphotungstic acid but are less numerous here than in areas where the tumor seems to have grown less slowly. In the rapidly-growing portion the cytoplasm of the cells is small and there are occasional mitotic figures. The nuclei arrange themselves at times into pseudorosettes. There are no giant cells with bizarre nuclei as usually seen in *spongioblastoma multiforme*. In the portion of the tumor which seems to have grown less rapidly, especially in the portion which formed a cauliflower excrescence, the nuclei are larger and more elongated. The cytoplasm is more voluminous and is often carried into a long tail. There may be one or two tails, that is, the cells may be unipolar or bipolar. At the surface of the excrescence the tumor cells have arranged themselves beneath a superficial membrane very much like spongioblasts about the central canal. The cyto-

plasm of the cells is attached to the undersurface of the membrane, and at times the opposite pole of the cytoplasm is carried some distance away from the membrane. These cells seem to form fibers quite frequently. Neurofibrils pass through the tumor in large numbers in some areas, in others neurofibrils are almost absent. An occasional nerve cell is seen in the tumor which seems to be part of the neoplasm, but for the most part the contained nerve cells are evidently of the bulb itself and the tumor has infiltrated the tissue about them. It seems quite likely that all of the nerve cells are not neoplastic. In conclusion, the neoplasm is a rapidly growing one which has arisen within the substance of the bulb. It is very vascular in some areas and quite avascular in others. Fibers are formed which are neuroglial in nature. Although the tumor lacks the features of the usual *spongioblastoma multiforme* it must be called by that name.

Diagnosis: Spongioblastoma multiforme.

Section of Pediatrics, February 10, 1927

THE EFFECT OF PARATHYROID EXTRACT ON TETANY AND RICKETS IN INFANTS

LYNNE A. HOAG

A potent extract of parathyroid glands prepared in the manner described by Collip[1] was used in the treatment of six patients suffering from infantile tetany. The subcutaneous injection of adequate amounts resulted in rapid improvement of the clinical symptoms and signs, and caused an increase in the serum calcium concentration to normal or nearly so in from thirty-six to forty-eight hours. This state of improvement could be maintained by the daily injection of suitable decreasing fractions of the original effective dose. Omission of the parathyroid extract injections early in the course of treatment was followed by a return of symptoms and a lowered serum calcium concentration. This relapse was less liable to occur when the injections had been continued for a few days before withdrawal of the hormone.

[1] Para-thor-mone, Eli Lilly Co., described in "New and Nonofficial Remedies" (J. A. M. A., Nov. 14, 1925, LXXV, 1559).

The individual response to the quantity administered was so variable that the safe selection of dosage could be guided only on the basis of frequently-repeated analyses of the concentration of serum calcium. From the results secured in these six cases it is felt that a safe minimum dose of parathyroid extract calculated to raise the serum calcium 1 mg. per 100 c.c. in the average patient with infantile tetany, is approximately 5 units per kilogram of body weight. On this basis one can calculate the total dose necessary to elevate the serum calcium to approximately 10 mg. per 100 c.c.[2]

This total dose may be given at four- to eight-hour intervals in twenty-four to thirty-six hours.

The administration to an infant with active rickets of 820 units of parathyroid extract in the course of twenty-five days produced no recognizable roentgenologic changes in the zones of provisional calcification in the radius and ulna. On the seventeenth day after the beginning of a seven-day period of intensive ultraviolet radiation, the same infant showed distinct roentgenologic evidence of healing.

Studies of calcium and phosphorus balance were conducted on six patients in an attempt to determine the origin of the calcium mobilized by the injection of parathyroid extract. One normal infant and three with rickets showed varying degrees of diminution in their retention of calcium during the periods of parathyroid administration. This diminution resulted in a potential loss of calcium from the body in two patients and an actual loss in the other two patients. The extent of this potential calcium deficiency bore no constant relation to dosage. Two patients with infantile tetany failed to show a decrease in their calcium retention when given parathyroid extract; in fact, both showed slightly increased retentions. It is interesting to note that the initially low serum calcium values in these two patients were never raised to a normal figure during the course of treatment, this fact perhaps accounting for the lack of increased overflow excretion in the urine and stools and suggesting the possibility of a serum calcium threshold.

[2] Example—An infant weighing 5 Kg., and having a serum calcium concentration of 6 mg. per 100 c.c., could be given 100 units of parathyroid extract in 24 to 36 hours [5 Kg. × 5 units × (10 − 6].

From these findings it is felt that the administration of parathyroid extract as a therapeutic agent is justified only when immediate and temporary elevation of the concentration of circulating calcium is desired over short periods of time.

Section of Ophthalmology, February 21, 1927

THE DEVELOPMENT OF THE GLAUCOMA SCOTOMA

A. H. Thomasson

Elliott emphasizes the importance of scotometry as a means of diagnosing early noncongestive glaucoma, placing this method first in the list of diagnostic procedures. It is now thirty-seven years since Bjerrum described the early glaucoma scotoma, pointed out its importance in the diagnosis of this disease and described the method by which it could be detected and studied, and yet it seems that American Ophthalmologists have given little attention to this important diagnostic measure. This paper is offered in the hope that it may stimulate a greater interest in this subject. It attempts a detailed description of the three types of the glaucoma scotoma, and the progressive changes that occur in each type until the field defect is well advanced. The types of the scotoma described are: (1) Single-winged vertical; (2) double-winged vertical; and (3) single-winged horizontal. It stated that there also probably exists (4) a double-winged horizontal scotoma, but this has not been seen in its early stage. Lantern slides were shown illustrating the various types of scotomata. These were all obtained from patients of Dr. A. Knapp, and were shown by his permission.

Section of Ophthalmology, February 21, 1927

HISTORICAL PERSPECTIVES IN OPHTHALMOLOGY

Arnold C. Klebs, Nyon, Switzerland

A very notable increase of interest in the history of Medicine has taken place in the United States during the last few years, stimulated by men of broad culture such as the late William Osler, Welsh, Cushing, Streeter and especially by the admirable systematic discussion of the subject in the textbook of Garrison. Efforts are made in various quarters towards making the culti-

vation of historical research a vital part of medical training; the fact that a historical habit of thought adds to the equipment of both practitioners and research workers is becoming widely recognized. The mere revelation of dates, of historical events, of the collections of old books and curios is helpful in this direction; the study of medical portraiture, of biography, of the intricacies of bibliography can become pursuits of absorbing interest well suited to dispel the tedium of professional routine. For critical analysis of historical evolution and for the philosophical appreciation of the relation of the various component factors to each other within this evolution, a deeper study of original sources becomes necessary, and it is most gratifying to note that in various parts of this country preparation also for such research work is being made.

The history of ophthalmology presents a well-tilled ground. Hirschberg and his school have laid its solid scholarly foundations, and in this country notably Drs. Harry Friedenwald and Casey Wood have made excellent contributions. The writer, having come in contact with ophthalmology but once in his life, when he prepared his inaugural thesis some thirty years ago, is unable to give more than superficial impressions, gathered in his general historical studies.

The larger part that optics occupies in ophthalmological science and practice bestows upon this branch of Medicine the right to truly scientific consideration such as no other possesses. If mathematic formulation is the criterion for a true science, as Descartes, Kant and Bertrand Russell held, then among all medical branches, and possibly in Biology, Ophthalmology holds first rank. But there is other basic knowledge needed by the ophthalmologist, knowledge of quantities that are not measurable or ponderable. It is that knowledge that comes through the careful training of both the cerebral and retinal eye in conjunction with that of the hand. It is the knowledge of the intelligent craftsman such as Hippocrates described so well in his famous expression of "tribe meta logoo." Philosophy evolving into Science by the road of mathematics, craftsmanship into art, seem to have thrived side by side during long ages without distinct influence of the one on the other. The former reached towering heights in Ancient Greece, the stream of the latter

seems to have flown steadily from the Orient to the Occident, along the route India, hellenistic-Alexandria, North Africa, Sicily, and Spain. Wherever the two streams met, as in Alexandria, in Byzantine realms, under Arab caliphs, during the so-called renaissance in the Middle Ages and way into our own times, practice could make notable strides ahead; wherever they flowed separately other cultural and political endeavors would prevail with the result of apparent medical stagnation.

An innate contempt which the man of the head seems to hold for the man of the hand has been in all times an obstacle to the harmonious evolution of the medical art. Ophthalmology has bridged the gulf more successfully than any other specialistic branch. In intimate contact with pure science, combining surgery with medicine, its adepts, in a limited field, have united in themselves, in their activities, the two historical streams, and thus pointed the way for an improved educational preparation of the larger field.

Section of Obstetrics and Gynecology, February 22, 1927

BRIEF DISCUSSION OF THREE CASES OF EXTRA-VESICAL URETERS

H. Dawson Furniss

Supernumerary ureters are quite common, but those with extra-vesical openings are rare—only 101 are reported in the literature. Of the 30 cases of supernumerary ureters that I have seen only three have emptied extravesically.

The condition should always be suspected when there is a history of constant dribbling, congenital, in addition to normal voiding.

The detection of the ureteral opening is at times very difficult, as this may be in the urethra, the vestibule of the vagina, or in the vagina itself. Frequently the function of the part drained by the ureter is insufficient to eliminate dye in concentrations that help in locating the orifice.

Methods of Diagnosis. History—the detection of the orifice of the ureter (at times after phenolsulphonephthalein, or in-

digo-carmine administration, irregularity of the renal pelvis as shown by pyelogram. Filling the bladder with indigo-carmine solution and administrating phenolsulphonephthalein intravenously. The leakage of a red or brownish-stained urine would prove an extra-vesical ureter (many times, however, the function is too impaired to eliminate the dye). At times a renal operative exploration may be necessary to locate the involved side. It must be remembered that 4 per cent. are bilateral—one of mine was.

Treatment has been by ligation of the ureters; implantation vaginally and abdominally of the ureter into the bladder; and resection of the kidney. The latter is the best procedure, and can usually be easily carried out. It removes the source of the trouble. With implantations there are often complications following—stricture, infection, and cystitis. In one of my cases I implanted the ureter into the bladder, and because of repeated attacks of kidney pain thirteen years later, resected the kidney.

Section of Obstetrics and Gynecology, February 22, 1927

UTERUS DUPLEX UNICOLLIS

(With Comments on Malformations of the Uterus)

Walter T. Dannreuther

The formation of a normal uterus is contingent upon the fusion of the lower half of the apposed Müllerian ducts, with disappearance of the intervening duct walls, so that a single chamber (the uterine cavity) is created. Muscular fibres are developed in the subperitoneal tissues of the Wolffian and genital mesenteries of the embryo, which is some way decussate and interlock, thus leading to a coalescence of the Müllerian ducts. If the genital fold proves stronger than these interlocking muscle fibres, union of the Müllerian ducts may be partly or entirely prevented, so that an intermediate arrangement becomes permanent. In most instances of malformation of the uterus there is a parallel development of the two sides, although in some

cases the growth of one side may be arrested, the other pursuing its normal course.

There are six well-definied variations in malformation of the uterus. Their recognition is of importance chiefly because of their influence on the child-bearing function, and the diagnostic difficulties they present when complicated by tumor formation, to which they seem to be prone. The author has had 13 patients in 21 years with malformation of the female pelvic organs, 11 of whom were married; 5 of the 11 married women had never been pregnant, but the other 6 produced collectively 16 children and 11 miscarriages.

The six commonly-recognized types of malformation are: (1) uterus unicornis, (2) uterus subseptus, (3) uterus septus, (4) uterus bicornis unicollis, (5) uterus bicornis bicollis, and (6) uterus didelphys.

The author outlines the history of a patient from whom a specimen was removed that does not conform exactly to the specifications of any one of these six types of malformation.

Bimanual examination disclosed a uterine corpus, normal in size, symmetry, consistency, and mobility, deviated slightly to the right. On the left side there was an enlarged, hardened, pyriform and symmetrical structure, arising from a broad attachment just above the level of the internal os.

On opening the abdomen in the mid-line, the posterior-superior aspect of two perfectly-formed uterine bodies presented. The one on the left was larger than the other, but palpation determined that this was due to the presence of an intramural fibroid. The cleft between the uteri extended downward to the level of the internal os, which was located at a joint just above the cervico-vaginal junction. The visceral peritoneum covering the bladder and uteri was smoothly merged with that of the cul-de-sac and rectum throughout the interuterine cleft. A supravaginal hysterectomy was done, after incising the peritoneum on the posterior margin of the sulcus and freeing the upper limit of the bladder.

On opening the specimen, it was evident that each uterine corpus contained a normal cavity, which communicated with a single cervical canal. The left uterus contained an encapsulated, fasiculated fibroid tumor. The specimen can not be prop-

erly classified as either a uterus didelphys or a uterus bicornis unicollis. It is not a uterus didelphys because of the single cervix and cervical canal; and the very deep cleft extending all the way down to the level of the internal os, with the so-called recto-vesical ligament lying in the sulcus, removes it from the group of bicornate uteri. It can best be described as a uterus duplex unicollis.

Section of Obstetrics and Gynecology, February 22, 1927

A REPORT ON SPERM EXAMINATIONS IN OBSCURE CASES OF STERILITY

G. L. Moench

In most cases of sterility it is not very difficult to find the underlying cause or causes. There are, however, some infertile marriages in which the husband has many actively motile spermotazoa and the wife, also, appears normal. In such cases relative sterility (or as I call it selective fertility), biological incompatibility, vaginal acidity, sperma immunity and psychic causes are often made responsible for the failure of the woman to conceive. I have previously, however, been able to show that these factors can only rarely be at the bottom of the trouble. Vaginal acidity due to lactic acid and of the same acidity as a 0.5 per cent. lactic acid solution, can not possibly cause sterility, as the sperma live for hours in a 0.5 per cent. lactic acid solution, as I have determined by my own observations. Furthermore, the normal sperma do not remain in the vagina for any length of time, and lastly, it must be remembered that the alkaline semen itself reduces the vaginal acidity. Sterility due to sperma immunity is also problematical. I believe that in the obscure cases of sterility we must seek our explanation in the abnormalities present in the male and female germ cells. It is of course impossible to examine the female sex cells directly. At the same time the menstrual history, the vaginal flora, the palpitation of the ovaries, etc., should tell us whether or not the ova are normal.

The male germ cells fortunately can be examined directly, but such an examination should be done very much more in detail than is usually the case. Williams and Savage have shown in animals, especially bulls, that the morphology of the sperm heads is the most important source of information as to the fitness of the cells for reproduction, and the percentage of abnormal sperm heads ejaculated determines the fertility of the animal.

Williams and Savage, therefore, counted the number of abnormal cells per thousand and then measured and plotted 300 sperm head lengths. The fertile bulls showed less than 166 abnormal sperma per thousand and little variation in the size of the sperm heads, so that the graphs from such bulls were high and steep whereas those from bulls with poor breeding records were lower and more sloping.

Although up to the present I have been able to examine relatively few cases it seems, as far as I have gone, that the conditions found to prevail in animals are also true of man. Certainly the abnormal spermal changes found in bulls are also to be seen in human semen. At the same time it is evident from my examinations that the limits of normal variation are much higher in the species *homo* than in the bull, unless indeed these findings indicate a lowered fertility of modern humans. The number of abnormal sperma in fertile men was at times almost twice as high as in fertile bulls, and the corresponding graphs constructed from measuring 300 sperm head lengths also showed a greater slope. To test the accuracy of the method a second series of 300 cells was measured in some of the specimens and resulted in almost identical graphs.

Frequency of sexual intercourse alone had very little effect on the percentage of abnormal sperma present in any given semen specimen, although it markedly reduced the total number of these cells. It would seem also that general physical health greatly influences spermatogenesis.

Illustrated with 9 lantern slides.

BOOK REVIEWS

A NEW HISTORY OF MEDICINE[1]

The volume before us forms one of the English Series, "The History of Civilization," edited by C. K. Ogden and Harry Elmer Barnes (American editors). It is handsomely printed on light-weight paper and illustrated with unique pictures of the better known leaders of medicine, with such other celebrities as Fernel, Le Clerc, Bidloo, Cowper, Buffon, Bonnet, Erasmus, Darwin and Frederick Dekker; also engravings representing medieval surgery, a medical consultation (16th century), uroscopy (17th century), and a labor case (17th century). A striking facsimile is that of the program of the first Medical Congress at Rome (1681–2). The chapters cover the evolution of medicine, Egyptian, Hindu and Oriental medicine, Greek and Alexandrian medicine (four chapters), Graeco-Roman medicine (five chapters), Islamic and Salernitan medicine, 16th, 17th and 18th century medicine (two chapters each), with terminal chapters on Organicism and Vitalism and the Evolution of Therapeutics. There is a separate chapter on the Hippocratic Oath and some twenty pages on Caelius Aurelianus, which seem a little out of proportion. The handling of the material is intelligent and the style is marked by an elegance and sobriety which suggest French models, indeed reads like a translation from the French. The viewpoint is, in fact, that of the classical French historians, with whose spirit the author, who holds the chair of his subject in the University of Geneva, is evidently imbued. He begins with the effective statement that to the uncultivated, medicine "is purely a procedure employed for the cure of disease. The physician is a kind of machine which furnishes remedies for human suffering"; whence he proceeds, by showing the dependence of rational medicine upon all the sciences, to the tactical position that the popular notion of medicine "leads us to conceive what probably was the conception of primitive man." The peo-

[1] An Introduction to the History of Medicine from the time of the Pharaohs to the end of the XVIIIth Century. By Charles Greene Cumston, M.D., with an Essay on the Relation of History and Philosophy to Medicine, by F. G. Crookshank, M.D. XXXII, 390 pp., 24 pl., 8°. New York, Alfred A. Knopf, 1926.

ple confuse general medicine with therapeutics, as did the primitive herb-gatherers and bone-setters. Cumston divides the progress of medicine into the instinctive (immanent) or intuitive, the theological, the metaphysical and the scientific phases, and emphasizes the important fact that to-day the science and the art of medicine are not really distinct but related, as basic scientific discipline and its practical applications, *i.e.*, as pure science and applied science. In the succeeding chapters, he gives valuable citations bearing upon Egyptian anatomy and semeiology, the legend of Jivaka as illustrating Hindu supremacy in surgery, an extended account of scientific tenets of the Ionian philosophers, of the Hippocratic Oath and Canon, of Galen, medical practice in Rome and so on, as indicated above. Very characteristic of the entire volume is the analysis of the philosophical ideas which activated the many theoretical systems of the great physicians before the scientific period, the line of thought in which Daremberg and Neuburger have preëminently excelled. This revival of medical philosophy, which is now in the air everywhere, for instance in the recent essays of Bier (Berlin), is the theme of Dr. Crookshank's introductory essay, which takes for its motto a passage from Théophile de Bordeu: "I was a dogmatist at 20, an observer at 30, an empiric at 40 and have no system at 50." In a very lively and discursive manner, Crookshank (his "Irish" well up) argues that the present chaos of "scientific" or laboratory medicine may be due to the old Cnidian error of sticking labels on to alleged final causes and assigning "specific" remedies therefor in the "tag you're it" spirit; while before the sick bed, the only medicine which is truly scientific is the Coan or Hippocratic, which sees diseases not as "clinical entities" (*i.e.*, sheer abstractions), but particular *cases* of altered physiology in different human beings. The patient is the thing; the disease is not an entity but only *aliquid entis*, a fluctuating variable attaching to the thing.

F. H. Garrison

THE HEALING POWER OF NATURE[1]

In the chaos of unrelated facts and conflicting opinions which characterizes post-bellum medicine, there is no trait more salient than the recent tendency to revamp or hark back to sundry theories of the past which had been seemingly forgotten, discarded or discredited as outworn doctrine. It is hardly a "magnificent gesture," as perusal of the volume before us will suggest. Such revivals only bear out the celebrated dictum of Cardinal Newman that people are more easily influenced by types (patterns) than by arguments, and less by ideas, pure reason and love of truth than by prevailing fashions. Thus, where a social group is timorous about changing its folkways, the conservatism, as Elsie Parsons maintains, is due to the primitive fear of unknown or untried conditions; where it reverts to time-honored custom (as Richard Wagner said, "with the greatest possible resolution") the same mental inertia is apparent. It would seem that the human mind is so circumscribed in scope and outlook that it is capable of producing only a limited number of philosophical, scientific, medical, literary, fictional, dramatic or artistic concepts, which, under various deceptive guises, occur and recur through space and time with monotonous regularity. Only music, and its analogue mathematics, have apparently limitless possibilities, but even here the mind will deal only with those it can assimilate or put to practical use. Stuart Mill's apprehension lest the number of viable permutations and combinations of musical sounds be exhausted is not without foundation. Mathematicians (as in Einstein's case) only cultivate such multiple algebras as are useful in physical science.

Of the various pathological theories which have profoundly influenced the medical mind at stated intervals, there is none more cogent, more self-evident, more likely to survive in the end than the ancient Hippocratic doctrine of the healing power of nature. Completely submerged, as it was, during the period of the post-mortem section (Rokitansky, Virchow) and the rise of the bacterial theory of disease, it again arose, Phoenix-like, to demonstrate its tough survival value, when inflammation itself

[1] Die Lehre von der Heilkraft der Natur im Wandel der Zeiten. Von Max Neuberger. 3 pl., 212 pp., 8°. Stuttgart, F. Enke, 1926.

came to be regarded as a defensive reaction, with antibodies, hormones or phagocytes as agents in the mechanism. Professor Neuburger, most philosophical of living medical historians, traces the ups and downs of this phase of medical doctrine with the calm judicial accuracy and critical insight of the true medical scholar. Sustained and propelled by the gentle movement of his beautiful style, we float over these "desperate seas" of erudition with ease and security, undismayed by the icebergs of Latin citation, which his running commentary disposes of in a way to be "understanded of the people." In the sixth book of the Hippocratic treatise on Epidemic Diseases (VI, 5, Littre, V, 314), we read that "Nature heals diseases" or more literally [Certain elements in our] "natures are physicians of diseases." It goes without saying that this doctrine has been supported by all the greater physicians, from Galen, Fernel, Paracelsus and Sydenham to Laennec and Virchow. Opposition to it, as in the case of Sylvius, Brown, Broussais or Gall, was based not unnaturally upon the fact, first stressed by the pathologist Gaub, that along with the defensive reactions of nature, there are direct and fatal repercussions of morbid processes upon the body which call for aggressive and purposeful counter-therapy; or as Robert Boyle put it: "Nature seems to be careful to produce, preserve and cherish things hurtful to the body, as well as things beneficial to it." The *via media* is obviously the safe line for the modern physician. Sometimes he must assist nature; sometimes he must wage a direct, frontal assault upon morbid processes. One of the most striking corollaries of the basic theorem in the Hippocratic Canon is to the effect that quartan fever exerts a beneficial effect upon tetanus (Aph. IV, 57) and epilepsy (Aph. V, 70; Epid. VI, § 6, 5), which has found its avatar in the recent treatment of neurosyphilis by superinfection with malarial or relapsing fever. There could be no more striking example of the breadth and depth of Greek medicine at its best. Those who wish to study these matters in detail will find no more faithful and reliable guide through the maze than Professor Neuburger's exhaustive and scholarly monograph.

F. H. Garrison

A NOTE ON GIROLAMO SEGATO

In an editorial on Dr. Valentine Mott, published in the Academy BULLETIN,[1] reference was made to the method of petrifying pathological preparations employed by "Signor Segato" at Florence, which intrigued Mott to the extent that, before the sudden demise of Segato, he had arranged to bring the penniless chemist to this country. It appears that much has been written about Segato by Italian savants.[2] He was born at Vedana (Belluno) on June 13, 1792; was well known in his day as a chemist, cartographer and traveler, and died suddenly of pleurisy at Florence on February 3, 1836, too suddenly, in fact, to communicate the secret process which died with him. He announced his discovery in Vieusseux's Anthology (1831, xliv, no. 12, 74) and, in his Florentine period, seems to have petrified some 300 insects, fish, reptiles and other animals, with about seventy-four anatomical specimens, obtained from the hospital, and to have made a mosaic table of 214 cross-sections of these specimens, obtained by sawing and polishing. After his death, many attempts were made to get at the secret of his method,[3] but without avail. In some of the specimens, the process of petrifaction was not complete and no inferences could be drawn from the chemicals found in his laboratory after his death. The preparations may be seen in the Anatomical Museum at Florence, in the Institute of the History of Science founded by Corsini in the same city, and in the Anatomical Museum at Perugia.

F. H. GARRISON

[1] BULL. N. Y. ACAD. MED., 1925, 2. s., I, 209–214.

[2] A. Wolinski: *Bull. Soc. geog. ital.*, 1892–3, 3, s., V–VI. A. Corsini: *Riv. d. bibliotoche*, 1913, XXIV, Nos. 6–9. L. Castaldi: Scritti biologici, Siena, 1926, 101–117, containing pictures of the bust of Segato in the Biblioteca Medica (Florence) and of three specimens of his petrified preparations.

[3] F. Cintolesi: L'imbalsamazione e le scoperte di Girolamo Segato e di Paolo Gorini. 8°. Firenze, tip. Fioretti, 1873. F. De Colo: L'imbalsamazione Umana. 16°. Milano, Hoepli, 1910.

Physician's Opinion as to Whether Patient Believed He Was in Danger of Death at a Given Time

It has become the custom during the past few years for the Internal Revenue Department of the Treasury to send agents to visit physicians in order to ascertain the physician's opinion as to whether a certain patient of his believed he was in danger of death at a given time.

It is commonly known that wealthy individuals give away part of their estate to their wives and children in order to avoid the payment of inheritance taxes, and it is assumed by the Internal Revenue Department that this is done more frequently when the wealthy individual is affected with some disease which may prove fatal.

The Revenue Act of 1926, under Section 1104, states that the Commissioner of Internal Revenue or an Inspector designated by him is authorized to examine any books, papers, records and memoranda, etc. Section 908 of the same act provides that the Board may summon witnesses, produce the necessary books, papers, etc.

On the other hand, Section 352 of the Civil Practice Act of the State of New York provides that: "A person duly authorized to practice physics or surgery . . . shall not be allowed to disclose any information which he acquired in attending a patient in a professional capacity. . . ." The privileges given under this section can be waived under Section 354 of the same act by "the personal representative of the deceased person."

There is no judicial decision on Section 1104 of the Revenue Act of 1926, and in regard to this section the counsel of The New York Academy of Medicine has given the following opinion:

> "In my opinion, if the personal representatives of the decedent have waived the right which the Statute has established, the physician can be compelled to submit to examination and to furnish his records.
>
> "It would, therefore, seem to me that, before a physician submits to questioning by a representative of the government, it would be necessary for him to obtain the consent of the personal representative of the decedent. Otherwise

he would be breaching the confidential relationship existing between the physician and patient.

"In the event that the personal representatives of the decedent have not waived the right above mentioned, or the consent of the personal representatives of the decedent is not obtained, it would not, in my opinion, be necessary to furnish the data, or render the opinion requested."

It would, therefore, seem advisable for physicians to secure the consent of a member of the family or an authorized representative of the deceased before giving confidential information to an agent of the United States Internal Revenue Office.

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London . . . 1927, 216 p.

Williams, J. F. Hygiene and sanitation.
Philadelphia, Saunders, 1927, 344 p.

Winterstein, H. Die Narkose. 2. Aufl.
Berlin, Springer, 1926, 474 p.

LIBRARY NOTES

From June 15th to September 15th, inclusive, the Library will be open on week days from 9:00 A. M. to 5:00 P. M., and Sundays from 10:00 A. M. to 5:00 P. M.

Owing to the fact that we have lately moved in, it will not be necessary this year to close the Library for the usual summer cleaning.

The Theses for the School Year 1926 of the Faculté de Médecine, 622 in number, have been received and are now catalogued and available in the Library.

There are quite a number of photographs and other portraits of doctors in the collection of the Academy which cannot be identified. The Librarian would be grateful if the Fellows—with good memories for faces—would ask to see them and help in this matter.

HOSACK BED FOR SICK AND NEEDY PHYSICIANS

Attention is directed to the following extract from the will of Mrs. Celine B. Hosack:

"I do give and bequeath unto my executors, hereinafter named, the sum of Ten Thousand Dollars, in trust, to apply and pay the same (or so much thereof as may be necessary) to The Roosevelt Hospital in the city of New York, to purchase a bed which, in memory of my husband, shall be known as the Hosack Bed, and which shall be occupied from time to time by such sick and needy physicians as may for that purpose be named or designated by the President and Treasurer for the time being of The New York Academy of Medicine."

DONATIONS TO THE LIBRARY FUNDS

Donations and bequests are solicited by The New York Academy of Medicine for the maintenance and expansion of the Library.

A donation or bequest of $5,000 or more will provide for a special library fund, the income of which may be used for the general purposes of the Library or restricted to the purchase of books and periodicals, as the donor or testator may indicate.

FORM OF BEQUESTS

The following is a brief legal form as a suggestion under which bequests may be made in behalf of the Academy:

I give, devise and bequeath unto "The New York Academy of Medicine" of the City of New York, State of New York, a corporation duly incorporated by the legislature of the State of New York by an act, entitled "An Act to Incorporate The New York Academy of Medicine," passed June 23, 1851, and amended June 4, 1853, June 2, 1877, and April 24, 1925.

DEATHS OF FELLOWS OF THE ACADEMY

HENRY COGGESHALL, M.D., 40 East 58th Street, New York City; graduated in medicine from Harvard Medical College in 1883; elected a Fellow of the Academy, June 4, 1891; died, May 24, 1927.

ABRAHAM ZINGHER, M.D., 47 West 69th Street, New York City; graduated in medicine from Cornell Medical College in 1908; elected a Fellow of the Academy, February 6, 1913; died, June 4, 1927. Dr. Zingher was a member of the Pathological and Bacteriological Society, a member of the American Public Health Society, a member of the American Immunity Society, and a member of the Society of Associated Alumni of Mt. Sinai Hospital. He was also attending physician to the Willard Parker Hospital.

JEREMIAH FRANCIS CALEF, B.A. Wesleyan Univ., 1877, M.A. Wesleyan Univ., 1880, M.D., Middletown, Connecticut; graduated in medicine from Yale Medical School in 1880; elected a Fellow of the Academy, May 6, 1897; died, June 8, 1927.

LEWIS DUNCAN MASON, M.D., 171 Joralemon Street, Brooklyn, N. Y.; graduated in medicine from Long Island College Hospital in 1866; elected a Fellow of the Academy, May 4, 1882; died, June 11, 1927.

1927

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